Greene MH, Clark WH, Tucker MA, et al: Acquired precursors of cutaneous malignant melanoma: The familial dysplastic nevus syndrome. N Engl J Med 1985 Jan 10; 312:91-97

Wright WE, Peters JM, Mack TM: Organic chemicals and malignant melanoma. Am J IndMed 1983; 4:577-581

The Occupational History

MANY ARTICLES on occupational medicine remind physicians in other fields of the necessity of taking a good occupational history along with the medical history. Towards this end, various formats and styles of history taking are presented in the literature. Most tend to be highly inclusive, complex and cumbersome to use in daily practice. At the other extreme, a physican who does not use any routine or format may be lost early on and abandon the quest for occupational illness after the single inquiry, "What kind of work do you do?" And, finally, unless familiar with the field and legal requirements, many will not know what to do with the information gathered by using most available formats. The following format is presented to aid physicians both in taking a history and in directing them in the use of the information. The form should be used following a work history and positive response to general inquiry of exposure to substances and workplace environments such as asbestos, heavy metals, carcinogens, pesticides, noise, solvents, arsenic, ethylene oxide, dusts and radiation.

The format provides space for a general work description, exposure data and legal limits of toxic substances and required health surveillance in California. This format can be tailored to a particular area or population by adding or deleting specific exposure categories. It is best used when provided to patients in advance of their appointment so that reference can be made to work records for accuracy. However, it can also be used effectively when completed in the waiting room and reviewed with the examining physician at the same visit. It is most effective if maintained and compared from year to year on subsequent visits. The form is entitled "Interim Toxic

Cal/OSHA INTERIM TOXIC EXPOSURE HISTORY FORM TODAYS DATE:
WITH REFERENCE TO THE PAST THREE (3) YEARS:

NAME BIRTHDATE SOCIAL SECURITY #

OCCUPATION JOB TITLE JOB DESCRIPTION HOW LONG HELD

WORK RELATED INJURY OR INDUSTRIAL ACCIDENT?
PLEASE DESCRIBE:

EXPOSURE DATA: PLEASE BE ACCURATE

| FOR THE EXAMINING ** DOCTOR

SUBSTANCE/CODE	EXPOSURES DATE, DURATION, AMT	PROTECTIVE EQUIP WORN: YES	PROTECTIVE EQUIP WORN: NO	ACUTE EFFECTS: YES	ACUTE EFFECTS: NO	LEGAL LMT: 8 HR TWA/ ceiling	In addition to a work & medical Hx and P.E., ADD:
ASBESTOS/5208j						'action' 0.1 fiber /cc air PEL .5 fibers/cc	over 40:pa cxr, stool blood test, PFTs qlyr/ 3 view cxr q3yr under 40:pa cxr, PFTs q 1 year.
13 CARCINOGENS* 5209g						NO DIRECT CONTACT	ANNUAL EXAM
VINYL CHLORIDE 3201k						PPM/5PPM Ø ON SKIN	LIVER FUNCTION TESTS
DBCP/ 5212m						PPB/ Ø SKIN/EYE CONTACT	SERUM ESTROGEN/ SPERM CT; LH/FSH REPRODUCTIVE HX
ACRYLONITRILE/ 5213n						1 PPM	STOOL BLOOD, CXY DETAILED NEURO EX
MOCA/ 5215k 4'4 METHYLENEBIS (2-CHLOROANILINE)						10ug/cc3/ 50 """air surface: 100ug/cm	CXR PA,U/A,CBC, LIVER FUNCTIONS. MOCA URINARY TEST IF EXPOSED MORE THAN 10 YEARS.
EDB/ 5219k ETHYLENE DIBROMIDE						130PPB Ø LIQUID on eye/skin	UNDEFINED AT THIS TIME
LEAD 5215						50 ug/M3 "action" at 30ug/M	ZPP,BLOOD LEAD, CREATININE,CBC, BUN,U/A.
PESTICIDES/ ORGANOPHOSPHATES.						Individual limits	RBC and plasma cholinesterase.
NOISE						90dBA/115	ANNUAL AUDIOGRAM 'action level' at 85dBA
RESPIRATOR USE: TYPE: DATE:		WHY WORN:		FOR HOW LONG:			SPIROGRAM,EKG, HEARING/VISION
ARSENIC 5214						'action' level 5ug PEL 10ug/m3	CBC,U/A,CXR PA, SPUTUM CYTOLOGY
EtO 5220 ETHYLENE OXIDE						'action' Ø.5ppm PEL 1 ppm	CBC, REPRODUCTIVE HISTORY

*13 CARCINOGENS: Acetylaminofluorene,Aminodiphenyl,Benzidene,Dichlorobenzidene, Dimethylaminoazobenzene,alpha-Naphthylamine,beta-Naphthylamine,Nitrobiphenyl, Nitrosodimethylamine,beta-Propiolactone,bis-Chloromethyl ether,Methyl chloromethyl ether, Ethyleneimine.

**For further information regarding periodicity of examination and details of followup of abnormal data, consult the individual Sections cited.

Figure 1.—California Occupational Safety and Health Administration interim toxic exposure history form.

Exposure Questionnaire" and was developed for and is currently in use in periodic health surveillance examinations of the California Occupational Safety and Health Administration (Cal/OSHA) industrial hygiene and safety engineer inspectors by participating physicians at eight clinics throughout California (Figure 1).

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REFERENCES

General Industry Safety Orders, Industrial Relations 8: Cal Admin Code §§5208j, 5209g, 3201k, 5212m, 5213n, 5215k, 5219k, 5216

Goldman RH, Peters JM: The occupational and environmental health history. JAMA 1981; 246:2831-2836

The Health of Refugees and Employment

IN THE WAKE of continuing civil and military strife and suppressive behavior by governments around the world, there has been an upsurge in immigration to the United States. In the two-decade span since 1961, a total of 7,815,000 people came to this country; in the five years from 1977 through 1981 alone, 2,651,000—or 34% of the total— arrived. Of particular health concern have been the more than 670,000 refugees immigrating since 1975 from Southeast Asia.

A variety of conditions has been documented at centers where numbers of refugees have been diagnosed and treated, including hepatitis B antigenemia, tuberculosis, parasitism (often with several agents), anemia, malnutrition, gonococcal infections and Hansen's disease. Internment before entry into the US has led to further health impairment. Subsequent study has disclosed primary resistance to antituberculosis drugs among Indochinese, the sudden unexplained nocturnal deaths among previously healthy men, dental problems, unfavorable pregnancy outcomes and a lack of understanding in the health care system of indigenous beliefs and practices involving self-care and attitudes toward, and expectations of, Western medicine.

While many of the immigrants have established their own businesses in big city enclaves, others have entered the labor market. With the passage of time and the acquisition of citizenship status, it is likely that there will be applications for employment among this group in manufacturing companies engaged in defense production. Both inplant health services and physicians conducting preplacement examinations should add certain case-finding procedures to their examination protocols that ordinarily are not included in the prehire evaluation or are not indicated in today's medical reviews of most job candidates.

The following procedures are suggested as components of the preplacement examination of refugees, particularly of those persons from Southeast Asia:

- A general physical examination.
- Tuberculin skin testing with subsequent chest radiography of persons having positive skin reactions. Referral to local or state health departments should be effected for the initiation of therapy. The Centers for Disease Control recommend further that a bacteriologic examination with smear culture and susceptibility studies be done in all suspected or follow-up cases.
- Serologic test for syphilis.
- Serologic test for hepatitis with forwarding of results when sources of general health and dental care have been established by the applicant or employee.
- Stool examination for intestinal parasites.
- Thick and thin blood smear tests for malaria for all persons with fever.
- Immunizations—tetanus toxoid, trivalent oral polio vaccine and others as indicated by age, previous immunization history or job assignment.

Particular clinical scrutiny must be conducted of food handlers, and appropriate treatment regimens initiated if parasitism involving *Giardia* and *Entamoeba histolytica* is encountered. Hepatitis B in a food handler presents a public health risk.

Certain culturally offensive practices should be avoided in the health assessment of Southeast Asian refugees:

- Complete disrobing of female patients (applicants or employees).
- Pelvic examination. This is usually not included in occupational medical practice, but, if indicated, it is not to be carried out on the first contact, and preferably should be done by a woman physician.
- Visible presence of an interpreter of the opposite sex during a breast or gynecologic examination.
- Negative judgmental attitudes toward traditional healing practices.
- Withdrawing numerous tubes of blood without proper warning or explanation.

As employment implies future visits to an occupational health facility, strict adherence to these recommendations will allow the establishment of trust and will ease further contacts required by either illness or surveillance programs.

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REFERENCES

Baron RC, Thacker SB, Gorelkin L, et al: Sudden death among Southeast Asian refugees—An unexplained phenomenon. JAMA 1983 Dec 2; 250:2947-2951

Barry M, Craft J, Coleman D, et al: Clinical findings in Southeast Asian refugees. JAMA 1983 Jun 17; 249:3200-3203

Hoang GN, Erickson RV: Guidelines for providing medical care to Southeast Asian refugees. JAMA 1982 Aug 13; 248:710-714

Jones MJ, Thompson JH Jr, Brewer NS: Infectious diseases of Indochinese refugees. Mayo Clin Proc 1980 Aug; 55:482-488

Muecke MA: Caring for Southeast Asian refugee patients in the USA. Am J Public Health 1983 Apr: 73:431-438

Health Risks in the Operating Room

ALTHOUGH HEALTH RISKS to patients undergoing surgical procedures have been widely recognized for many decades, it is only since the 1970s that the health risks to workers in the operating room have received similar attention.

There are several possible sources of health risk to operating room-based personnel. The most studied source is pollution from gases, which include volatile anesthetics, methyl methacrylate (used in surgical cements) and various sprays. Although more speculative, other sources include ionizing radiation, infection and stress. While causal relationships have not been firmly established, chronic exposure to anesthetic gases is most often implicated as the etiologic agent of increased risk.

Epidemiologic studies have identified several possible health hazards to operating room personnel. The most widely studied effects deal with reproductive outcomes. For example, it is generally accepted that female staff working in the operating room have a spontaneous abortion rate about twice that of various control groups. The results are equivocal for